

# Personal Data Form

Last Name, First Name, Middle Name:		SSN:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date Scheduled:	<b>Step 2: Pre-Examination User Key</b> ▶ CIV-DD Form 2807-1 attached <b>Step 3: See Note 2 - FAA Confirmation #</b> ▶		
<input type="checkbox"/> AFROTC CADET <input type="checkbox"/> RESERVE <input type="checkbox"/> GUARD <input type="checkbox"/> ACTIVE DUTY <input type="checkbox"/> CIVILIAN			
Home of Record (Address)		Emergency contact: (Name, Relation, Address, and Phone Number)	
Current Address		Date of Birth Day: Month: Year:	Place of Birth
Home Phone (include area code)	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hispanic White <input type="checkbox"/> Hispanic Black <input type="checkbox"/> Asian Pacific Islander		
Cell Phone (include area code)	Duty Phone: DSN:	Email Address:	
<b>ACTIVE DUTY, GUARD, AND RESERVE</b>	<b>AFROTC CADETS</b>	<b>CIVILIANS</b>	
How long have you been in the military? Years:                      Months: Rank: Major Command: Base: Squadron and Unit:	Det #: College:  Det NCO & Phone #:	Program Manager or POC Name:  Address & Phone #:	
1	<b>Have you had corneal refractive surgery (CRS) (IF YES, CLICK LINK FOR WORKSHEET)? Example: PRK, LASEK, or LASIK eye surgery</b> <input type="checkbox"/> No ▶ Continue to next question <input type="checkbox"/> Yes ▶ You must send all pre and post-surgery reports and 6 month eval 45 days prior to your appointment.		
2	<b>Please specify duty you are applying for:</b> <input type="checkbox"/> Pilot <input type="checkbox"/> RPA <input type="checkbox"/> Flight Surgeon		
3	<b>A) Do you have a family history of diabetes? If so, please specify relation of family member.</b>	<b>B) Were you born prior to 37 weeks? If so, please specify gestational age.</b>	
4	<b>Have you had an FAA exam within the past 36 months? (FAA CLASS III – CIVILIAN STUDENT PILOT CERT'S NOW VALID FOR 5 YEARS – THIS ALLOWS FOR TIME PERIOD BETWEEN FCI EXAM DATE AND FIRST IFS TRAINING DATE)</b> <input type="checkbox"/> Yes ▶ Enter "NA" in Step 3 above and Go to next question. <input type="checkbox"/> No ▶ If no, <a href="#">CLICK HERE</a> to register for your FAA Class 3 exam and enter your FAA <a href="#">MedXpress</a> confirmation number in Step 3 above.		
5	<b>Do you have a DOD/Military ID card?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No ▶ Please provide Driver's License information below		
Driver's License State:		Driver's License #:	
<b>Women: please provide copies of pap results <u>AND</u> office notes (exam notes) completed within the last 11 months, if applicable.</b>			
Date of last pap:		Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	

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If you have ever had or have (birth to present) any of the medical conditions listed below, we will require more information. Please click on the corresponding condition on our website to obtain the questionnaire, please answer all questions. You must submit the completed questionnaire along with all other required documents.

ADD or ADHD  
Motion sickness  
Sleepwalking  
Bedwetting  
Kidney stones  
History of asthma

Head injury or loss of consciousness  
Headaches  
Allergies  
Corneal Refractive Surgery (PRK, LASIK, or LASEK) checklist  
GYN (Women only)

## Ophthalmology Questionnaire

Please check YES or NO to the following questions and explain in the space provided.

YES NO

1. Have you ever had any type of eye surgery to include: refractive eye surgery (PRK or LASIK), eye muscle surgery, eye lid surgery, cataract surgery, ect.?	<input type="radio"/>	<input type="radio"/>
If yes, please list type and when:		
2. Have you ever been diagnosed with lazy eye or amblyopia? Did you have to wear an eye patch as a child or glasses in childhood?	<input type="radio"/>	<input type="radio"/>
If yes, please list when:		
3. Have you ever had any trauma to or around your eye? Have you ever broken a bone in your facial area?	<input type="radio"/>	<input type="radio"/>
If yes, list where and when:		
4. Have you ever worn contact lenses to include soft and hard contacts, or the one's you sleep in at night and take them out in the morning? (Soft contacts must be out for 30 days and hard contacts must be out for 90 days prior to 1 <sup>st</sup> date of appointment or <b>your cycloplegic eye exam must be deferred until that parameter is met</b> )	<input type="radio"/>	<input type="radio"/>
If yes, please indicate what type and list the last time you wore them, even for an hour:		
5. Have you ever failed depth perception or had any known issues with depth perception?	<input type="radio"/>	<input type="radio"/>
If yes, please explain:		
6. Have you ever failed color vision or had any known issues with color vision?	<input type="radio"/>	<input type="radio"/>
If yes, please explain:		

**Privacy Act-1974 as Amended applies.** This form contains information which must be protected IAW DoD 5400.11 and it is Official Use Only (FOUO). In addition, this transmission may contain information covered under the Privacy Act, 5 USC 552(a), Health Insurance Portability and Accountability Act Public Law 104-191, and DoD Directive 6025.18, DoD Health Information Privacy Regulation. It must be protected in accordance with those provisions.